HUBBARDS
FAMILY DENTAL CLINIC

New Patient Form

PLEASE PRINT THIS PAGE and bring the completed form to your appointment with Dr. DeViller

The following information is required to thoroughly diagnose any condition and to give the highest possible standard of professional services. All information will be kept strictly confidential.

Date: _____

PERSONAL INFORMATION (Please print)

Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. _____
(given name) (family name)

Address:_____

Date of birth: _____ (Day/Month/Year)

Telephone: Res. _____ Business (& ext): _____ Cell: _____

Email: _____

Occupation: _____ Place of Business: _____
(of parent if under 16yrs.) (of parent if under 16 yrs)

Person responsible for account: ☐ Self ☐ Other _____

Dental Insurance: ☐ Yes ☐ No If yes, insurance company name: _____

Contract # _____ Group (Policy) # _____

Subscriber _____ % of Basic Coverage _____

Physician: Name _____ Telephone _____

Health Card # _____

In case of emergency please notify: Name _____

Relationship to patient: _____ Telephone _____

How did you find out about our office?
☐ Yellow Pages ☐ Walk in ☐ Google ☐ Other ☐ Referred by: _____

PERSONAL INFORMATION (Please print)

1. Are you now under the care of a physician (or have you been in the last 6 months) ☐ Yes ☐ No
a) If so, what is the condition being treated? _____

2. Have you had any serious illness or operation? ☐ Yes ☐ No
a) If so, what is the illness or operation? _____

3. Are you taking any drug or medicine? ☐ Yes ☐ No

Specify: A) Drug _____ Reason _____
B) Drug _____ Reason _____
C) Drug _____ Reason _____
(Please attach additional sheet/photocopy if insufficient space)

4. Are you ALLERGIC or have you every reacted adversely to any drug or medicine:

☐ Aspirin
☐ Codeine
☐ Penicillin or other antibiotics
☐ Local anaesthetic (freezing)
☐ Analgesics (pain killers)
☐ Barbiturates (sleeping pills)
☐ Sedativessulfonamide (sulfa)

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5. Do you have or have you had any of the following diseases or problems:
a) Rheumatic fever, rheumatic heart disease, or heart murmur? ☐ Yes ☐ No
b) Congenital heart lesions? ☐ Yes ☐ No
c) Cardiovascular disease: ie. heart trouble; heart attack; high blood pressure; arteriosclerosis (hardening of the arteries); stroke? ☐ Yes ☐ No
d) Chest pains or shortness of breath? ☐ Yes ☐ No
e) Prosthetic implants: ie. heart valve, shunt? ☐ Yes ☐ No
f) Asthma, hay fever, skin rash, allergies, sinus trouble, bronchitis? ☐ Yes ☐ No
g) Fainting spells or seizures: ie. epilepsy? ☐ Yes ☐ No
h) Diabetes? Any family history of? ☐ Yes ☐ No
i) Kidney disease? ☐ Yes ☐ No
j) Hepatitis, jaundice or liver disease? ☐ Yes ☐ No
k) Endocrine disorders: ie. thyroid disease? ☐ Yes ☐ No
l) Breathing disorders: ie. tuberculosis, emphysema? ☐ Yes ☐ No
m) Gastrointestinal disease: ie. ulcers? ☐ Yes ☐ No
n) Nervous disorder? ☐ Yes ☐ No
o) Bone, muscle or joint disorder: ie. arthritis? ☐ Yes ☐ No
p) Cancer? ☐ Yes ☐ No
q) Venereal disease? ☐ Yes ☐ No
r) AIDS or AIDS-related complex? ☐ Yes ☐ No
s) Injury, surgery, x-ray therapy to your face & jaws? ☐ Yes ☐ No
t) Tendency to faint? ☐ Yes ☐ No
u) Frequent to severe headaches? ☐ Yes ☐ No
6. Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma? ☐ Yes ☐ No
a) Do you bruise easily? ☐ Yes ☐ No
b) Do you have any blood disorder? ☐ Yes ☐ No
7. WOMEN - Are you pregnant? (Due Date) _____ ☐ Yes ☐ No
8. Do you have any disease or problem not listed above that you think we should know about? ☐ Yes ☐ No
If so, please explain _____
9. Do you smoke? If so, how much _____ ☐ Yes ☐ No
10. Do you drink alcoholic beverages? If so, how much _____ ☐ Yes ☐ No

DENTAL HISTORY

1. Do your gums bleed when: ☐ Brushing ☐ Flossing ☐ Spontaneously
2. Do your gums feel swollen or tender? ☐ Yes ☐ No
3. Do you catch food between your teeth? ☐ Yes ☐ No
4. Are you aware of any loose or painful teeth? ☐ Yes ☐ No
5. Do you object to dental x-rays? ☐ Yes ☐ No
6. Are you nervous about dental treatment? ☐ Yes ☐ No
7. Does your jaw crack, pop, click or grate when you open wide? ☐ Yes ☐ No
8. Do you grind or clench your teeth? ☐ Yes ☐ No
9. Do you get frequent headaches or jaw pain? ☐ Yes ☐ No
10. Are you satisfied with the color, shape and appearance of your teeth? ☐ Yes ☐ No

TREATMENT CONSENT

This is to certify that I, the undersigned, consent to the dental procedures discussed and agreed to be necessary or advisable, including the use of local anaesthetic and/or x-rays as indicated.
I fully understand office policy, and I will assume responsibility for fees associated with those procedures performed.

_____ _____
Signature Date